EXHIBIT 11

In the Matter of:

Jonathan R., et al.,

vs

JIM JUSTICE, et al.

CYNTHIA PARSONS

June 27, 2024

5010 Dempsey Drive
Cross Lanes WV 25313
304-415-1122

IN THE UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF WEST VIRGINIA
AT HUNTINGTON

JONATHAN R., minor, by Next Friend, Sarah DIXON, et al.,

Plaintiffs,

-vs- Case No. 3:19-cv-00710

JIM JUSTICE, in his official capacity as Governor of West Virginia, et al.,

Defendants.

DEPOSITION OF CYNTHIA PARSONS

The deposition of Cynthia Parsons was taken on June 27, 2024, at 8:56 a.m., at 2116 Kanawha Boulevard, East, Charleston, West Virginia.

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Also Present: Cammie Chapman, Esq.
Steve Compton - Via Zoom

I N D E X

CYNTHIA PARSONS,

called as a witness, first being duly sworn by the Court Reporter/Notary Public, testified as follows, to wit:

EXAMINATION

BY MR. WALTERS:

Q. Ms. Parsons, could you please state your full name?

A. Cynthia Ann Hammock Parsons.

Q. Ms. Parsons, where are you currently employed?

A. West Virginia Department of Human Services, the Bureau for Medical Services.

Q. BMS?

A. Uh-huh.

Q. Do you still call it DHHR?

A. No. The name got changed.

Q. I know that. But do you still call it DHHR?

A. We practice -- we practice saying it correctly.

Q. Okay. Don't hold it against me if I call it DHHR.

A. That's okay.

Q. And I'm sorry. What's your position with BMS?

A. I'm the director of behavioral health and long-term care services.

Q. Okay. And how long have you been in that position?

A. That particular position would be four years now.

Q. All right. Before we get started, have you had your deposition taken before?

A. Years ago, yes. I used to be a therapist, yeah.

Q. Oh, okay. So you've been through it multiple times?

A. It has been a few years. Yeah, it has been about 16 years ago.

Q. Let me go through a couple of the ground rules you already know. But let me state them anyway. Obviously, I am going to be asking you questions. You are going to be giving me answers. Make sure that I finish asking my question before you start talking even though you know what I'm going to say. Our court reporter can only take

down one of us at a time, so we try not to talk over each other. Otherwise, she starts kicking me.

If I ask you a question that you don't understand, or when I ask you a question that doesn't make sense, please ask me to repeat it. Make sure we are clear and on the same page, and we understand you are answering the same question I am asking.

I don't expect this to be a very long deposition. But if you need -- we are on Zoom as well. I keep forgetting that. I don't expect it to be a long depo. But if you need a break, let us know. I will be happy to accommodate you. And if you have any questions, by all means, let me know.

What did you do to prepare for your deposition here today?

A. I worked with Kendra and Julia. And we had probably 20 hours' worth of speaking.

Q. Okay. And as part of being a 30(b)(6) deposition, did you do any type of investigation or research into the topics

other than discussions with the attorneys?

A. No.

Q. The main thing that -- I mean, obviously, the topic here is actions taken to increase number of type, availability of community-based services, including wrap-around services.

A. Uh-huh.

Q. So tell me, generally speaking, what has DoHS done to increase the number and type of availability of community-based or wrap-around services?

MS. DOTY: Objection. Outside of the scope. We have agreed that Ms. Parsons is being designated to speak only with respect to Medicaid-covered services.

MR. WALTERS: Right. And that's fair.

Q. And I am asking you with regard and in the scope of Medicaid-offered services.

A. One of the first things we did was expand ACT Services. So individuals 18 to 21, which is still under the child age limit

-- we gained two providers. That included Northwood and Eastridge.

We also worked on increasing reimbursement rates for behavioral health community-based services for 5 percent total. We were able to take a pilot program -- which is Mobile Crisis Services for Children. And we did the sustainability plan and got a state plan amendment approved by CMS for us to reimburse for that service.

We also included the CSED Waiver. So CSED Waiver is a community-based program that we got approved also through a 1915(c) through CMS for children up to the age of 21. And there was also a CHIP implementation plan -- which I was not a part of that. But there is a CHIP implementation plan.

Q. With regard to the ACT Services, how many children -- when was that implemented?

A. ACT itself has been around since about 2008. So it has been existing since then. We have had a state plan amendment

approved since then. We have always allowed 18 to 21-year-olds to be a part of that program. We just expanded to two more providers to ensure statewide coverage.

Q. Okay. And those two providers were in the northern part of the state?

A. Northwood, Northern Panhandle. And Eastridge is the Eastern Panhandle.

Q. When were those two providers added?

A. I think 2022.

Q. Do you know as of today how many foster care -- or children in DoHS custody are currently receiving services through ACT?

A. I do not know the total number.

Q. Do we know whether or not adding those providers increased the number of children being provided services through ACT?

A. It would have provided access. So you have to meet admission criteria. So if certain individuals in that age group met admission criteria, then they would be able

to get the service in those areas.

Q. So as part of expanding those services, you added providers. But we don't -- DoHS doesn't know whether or not adding those providers actually increased the amount of individuals actually receiving services; is that fair?

A. I don't know that number today.

Q. And when was the CSED Waiver Program created?

A. We were approved in 2020.

Q. What is the purpose of the CSED Waiver Program?

A. So CSED Waiver is a program developed to ensure that children could stay in their community and receive wraparound services and other services. It's to ensure that there's access at the community level so they don't have to go to residential or facility-based care.

Q. You say access to facility level to make sure they don't have to go into residential care. Does it also provide services to individuals on wait lists or

waiting to receive residential care services?

A. Yes. We have interim services. But again, the total goal is to ensure they stay in the community. It is not really used as a fail-safe to hold till they get in residential care. It can be. But the whole point is -- we feel like we could integrate services while they are living at home with the family and the community so they never have to go to facility-based care.

Q. Okay. And are you aware of the wait lists associated with the CSED Waiver Program?

A. I do have a wait list. CSED Waiver as of June 14th was 30.

Q. And what efforts, if any, are DoHS taking to reduce the wait list?

MS. DOTY: Objection. Vague.

Q. Go ahead. Yeah. When she objects, you can go ahead and answer unless she instructs you not to answer. When she does that, that means I asked a really bad question.

A. We also have other services through Medicaid that they can receive. So you still have therapies you could receive from licensed behavioral health centers. You have QHCs, licensed independent medical social workers, LPCs, and licensed psychologists. So there are other services available while children are on the wait list.

Q. Okay. And I appreciate that. I understand that they can receive other services. But is anything being done to actually limit the amount of children that are currently on the wait list?

A. Yes.

MS. DOTY: Objection. Vague.

Q. Go ahead.

A. So we are expanding provider network adequacy. So our managed care organization who has the CSED Waiver, they have to ensure that we have provider adequacy to do that. So they are constantly recruiting. So, you know, they are attritioned -- you know, we are not losing

providers. We are gaining providers usually on a quarterly basis.

Q. Okay. And that particular -- the wait list for CSED has been -- how long has that been an issue?

MS. DOTY: Objection. Mischaracterizes testimony.

Q. Go ahead.

A. I mean, beginning the program. Because it was during the pandemic. That would probably change the answer because, you know, when you start a program during the pandemic and everybody was at home. So it is very hard to explain in the beginning was there ever a wait list versus now.

Q. Understood. How about since 2021?

A. Again, we were still under the emergency pandemic order.

Q. 2022?

A. Still under the emergency pandemic order.

Q. So with regard to the emergency pandemic order in 2022, what effect would that have on the CSED wait list?

A. So you might have families that did not want providers to come into the home to do service out of fear of getting COVID. So that would have caused, you know, possibly people to wait on the wait list till it was safer they felt for the providers to come in the home to deliver services. So families have a choice.

Q. What organizations provide CSED Waiver services?

A. Licensed behavioral health centers.

Q. Okay. And are you aware that those behavioral health centers are the ones that actually have the wait list -- or I shouldn't say also -- but also have wait lists with regard to providing services to the children that need those waiver services?

MS. DOTY: Objection. Vague.

A. So we have Aetna, again who is our managed care organization who does that. They give us a total wait list number.

Q. Right.

A. And they work with those providers

to help them onboard individuals to do the services. So if you are like short a therapist and can't take more on the caseload -- Aetna is actively working with them to help them retain and recruit.

And then they also have the ability to do geographic exclusions. So CMS grants our ability to do that. So if someone -- if there's an LBHC in a certain area that is full that you are able to use someone for -- outside of that catchment area to deliver those services.

Q. Okay. Let me ask you this way. Since 2022, has DoHS done anything to address the wait list issue with the CSED Waiver Program -- since 2022?

A. Can you clarify what you mean by --

Q. Well --

A. -- do something?

Q. Well, has any actions been taken to address the fact that there is a waiver of -- I'm sorry -- that there is a wait list on the CSED Waiver Program since 2022?

A. So they also can receive interim

services through the Bureau for Behavioral Health and also through Safe at Home.

Q. Right. I understand that. I want to know if there has been any actual -- I mean, is there anything that you can point to that DoHS has done since 2022 to address the CSED Waiver issue?

MS. DOTY: Objection. Vague.

Q. I mean, I know there's other services provided.

A. Right.

Q. Is that the only thing that --

A. Well, I mean, like I stated, when you have a wait list, it is because you have a lack of providers. So that's why I was explaining with Aetna, how they were working with to develop more providers and use geographic exclusion to ensure we get kids treatment in a timely manner.

Q. And they started doing that in 2022, or they've been doing that all along?

A. We have been doing that since the beginning. But again, pandemic put a little bit of a kink in that.

Q. Got you.

And that's kind of what I am trying to zero in on. Has anything different been done? And the reason I am pointing to 2022 is -- according to the WV report, 31 percent of the organizations that offer CSED Waiver reported that they had wait lists.

So that 31 percent in 2022, you know, there is a finite number. And according to what you're telling me, there is already efforts and a way to avoid the wait lists. Was anything different done?

A. There has been no changes since '22.

Q. Okay. Are you aware of that -- from 2022 to 2023, that number went from 31 percent to 57 percent?

MS. DOTY: Objection. Assumes facts not in evidence.

Q. Just asking if you are aware of that?

A. I am not aware of the percentage number.

Q. I think you started off by telling

me that the main focus of the CSED Waiver Program was to reduce number of children going into residential care; is that fair?

A. That is correct.

Q. Okay. And has that happened?

A. We have had cases where children -- it may even recommend that they would go to residential care. But we were able to put CSED in place to keep them in their community.

Q. Do you have any type of number that represents in the last two or three years how many children have been prevented from going into residential treatment through the CSED Waiver Program?

A. I do not, no.

Q. Is there any way to track whether or not CSED Waiver Programs are actually being successful?

A. We do have outcomes and evaluations required from each care organization.

Q. Do any of those outcome metrics include tracking or estimating the number of children that are being prevented from going

into residential treatment?

A. I do not have that number today.

Q. I'm not asking for the number. I'm asking if the number is actually tracked?

A. I do not know if it is tracked at the exact way that you are stating.

Q. Do you know of any way it is actually tracked?

A. We do do tracking on those children. But again, it could be a documentation review. It could be a referral review. But I am not sure if there is an exact mapping of that.

Q. Explain to me how the CSED referral works.

A. Okay. Again, it can happen multiple different ways. So someone could call 988, or the Children's Mobile Crisis Line. Education can refer. Parents can self-referral. And even providers who are treating individuals in the community can refer. So there's multiple ways that someone could be referred to the program.

Q. Bureau of -- BSS -- is it still

BSS?

A. It is.

Q. Trying to keep up.

A. That's okay.

Q. You guys keep changing too much.

Do some referrals come through BSS?

A. They do. The workers can refer as well. They work with the family typically to do that, yeah.

Q. Is that where the majority of the referrals come from?

A. I don't have exactly the number. I mean, it just comes through different multiple things. I would say the majority probably do come from workers. But again, I don't have exact numbers in front of me.

Q. And when the child is put into a placement -- foster child is put into placement, the BSS worker -- is there a requirement that the BSS worker does an assessment to determine if that referral needs to happen?

A. It is not -- I wouldn't say the worker has an assessment. I think the

worker reviews the case. And I think that they refer appropriately. Because we have other waiver programs, not just CSED. So an example could be a child with a cognitive impairment. They may refer them to the IDD Waiver. So there is multiple ways workers look at the case I think to ensure that they have -- you are referring appropriately to the programs needed.

Q. Understood.

What is IDD Waiver?

A. Intellectual Disabled Waiver. They are for individuals with cognitive impairments or severe developmental disabilities. It is also a 1915(c) Waiver.

Q. And before I leave CSED, does CSED Waiver Program track the number of children that end up in residential treatment that received CSED Waiver Services?

A. We are tracking that as well.

Q. What does that number look like?

A. I don't have that number.

Q. Do we know if that's increasing or decreasing?

A. I don't -- I can't make a judgment call on the last time I reviewed that.

Q. With the IDD Waiver Program -- let me back up just a second. You mentioned that that's one of the type of referrals that could occur, as well as -- as well as ACT, as well as CSED, as well as IDD. All of those could be referrals done by the BSS worker, correct?

A. Absolutely.

Q. And is that assessment done through an acronym referred to as CANS?

A. We do use CANS and CAFAS to help make determinations.

Q. And of the two -- those are the only two, right?

A. There is PECFAS. But PECFAS is more for the adult side of things.

Q. Yeah. And is it my understanding -- or is it fair to say that CANS is kind of becoming the go-to?

A. Yes. We use it, and multiple states use it, for assessment reasons.

Q. Okay. And what does CANS stand

for?

A. Children -- right off the top of my head -- Children --

Q. Hold on a second, and I will tell you.

A. I have a lot of abbreviations running in my head.

Q. You and me both. Is it Child Assessment Needs and Strengths?

A. Needs and Strengths, yeah. I couldn't figure out the S. But yes, that's correct.

Q. Yeah.

When is a CANS assessment done by a BSS worker?

MS. DOTY: Objection. It's outside of the scope.

Q. At what point -- when a child enters into DoHS custody, at what point is a CANS assessment done?

A. It can happen at any point. So it is not just -- you know, you are of course trying to do it on the front end of things. But at any point you can do a CANS

assessment.

Q. Is there a requirement that it be done within a certain amount of time from when the child is placed into foster care?

MS. DOTY: Objection. Outside of the scope.

A. I couldn't answer that. I am from Medicaid. So I don't know.

Q. Understood.

And so from a Medicaid standpoint, you don't know at what point in time a child who enters foster care is determined to need or not need those Medicaid services?

A. That's not connected to Medicaid exactly. So that's -- you know, CANS is an overall assessment for children. And there is other, you know, assessments. Somebody might do a psychological evaluation as well to establish medical necessity.

So Medicaid is the payor. So we -- you know, based upon assessments that are done -- it could be multiple assessments. That determines medical necessity and determines levels of care needed and things

like that. So it is not just one thing that could make that determination. There could be multiple pathways. But CANS is required -- one of the required assessments.

Q. When a child enters the foster care system, enters DoHS custody, what's your understanding of how it is determined whether or not that child needs IDD Waiver Services or CSED Waiver Services?

MS. DOTY: Objection. Outside of the scope.

A. Again, I am the payor. So that is not connected to the part that I do with the worker.

Q. So you don't have any information as to whether or not the services were actually -- how it is being determined if those services are needed or when it has been determined if a child needs those services; is that fair?

A. We pay, once it is established, whatever service that they are needed.

Q. So when we talk about the wait lists with CSED Waiver Program -- and we

will get into the ones with IDD Waiver and a couple of others -- you wouldn't have any information as to whether or not there is children out there who have not yet been assessed that would also be on that wait list?

A. I would not have that information.

Q. Okay. Back to -- real quick, back to the CSED Waiver Program. You told me that you are in the process of tracking children that receive CSED Waiver Services and end up in residential treatment, correct?

A. Our managed care organization is tracking that.

Q. How is that being tracked?

A. I wouldn't be able to explain the process. We order that their managed care organization develop an ability to do that.

Q. Do you know if they are actually doing that?

A. I have seen reports, but I can't tell you what was on the last report.

Q. No. I just want to make sure that

it is -- telling them to do something and seeing that they are actually doing it are two different things. So you have actually seen reports that are tracked?

A. I have seen a report. But again, I can't tell you the exact algorithm that they use to develop that report.

Q. Sure.

Explain to me what IDD Waiver services are.

A. So for children and adults who have, again, cognitive impairments, severe developmental disabilities, the IDD Waiver is used to have services. And IDD Waiver has been around probably 30 years in West Virginia. And that really is the goal, is -- I am sure you have heard of group homes and that type of things like that.

So the goal of IDD Waiver was to have individuals be able to stay in their community and get programs such as respite or day rehabilitation programs, personal support services and things like that. So similar to CSED, but you are talking about a

different target population.

Q. And that's everything from infants to seniors, correct?

A. I think you have to be -- and again, please don't quote me because I don't do IDD Waiver. I think you have to be at age four and above before you can apply for the IDD Waiver.

Q. And specifically with regard to children in foster care, are you aware that there are wait lists for IDD Waiver services?

A. Again, I don't do ID Waiver. So I don't know -- have no access to that information.

Q. Okay.

A. That's a different section of Medicaid.

Q. Got you.

IDD Waiver would be considered community-based services, wouldn't they?

A. It is under the home community-based services rule.

Q. But because of the section of BSS

that you work for, you don't -- you can't testify about anything --

A. I'm BMS.

Q. I'm sorry?

A. I'm BMS.

Q. BMS. Sorry. I've even got it written down.

A. So you have different 1915(c)'s.

Q. Right.

A. And IDD is one of them. And it is under a different section at our bureau.

Q. What about positive behavioral support services?

A. So we have always had behavioral manager services. And positive behavior supports is an evidence-based model. So we are in -- we are requiring -- we are redoing our policies right now to have providers use that particular evidence-based model when they are doing positive -- positive behavior support is just like a form of behavior management. And typically there is an implementation in development. So you develop a plan, and positive behavior

supports helps the families and individuals working with the individual to implement the set plan.

Q. And who provides those services?

A. Licensed behavioral health centers.

Q. And what if anything has DoHS done in the last three years to increase the accessibility to the licensed behavioral health services specifically for providing positive behavioral support?

A. BBH -- and again, I do not work for BBH -- created a pilot to work with Concord University to develop certification for that evidence-based model. We in turn took that pilot, and we are now drafting out policy and developing rates and codes so it would be a billable service at Medicaid instead of just behavior manager services without an evidence-based model.

Q. So that's something that you are currently doing to increase accessibility to BPH -- PB -- wow -- positive behavioral services?

A. PBS.

Q. PBS?

A. Yes.

So when you create a rate and a code, it enables sustainability for providers to ensure that they will be paid for services using certain models or certain services.

Q. Okay. And when did that -- when did DoHS begin working on that model or begin working on making that a separate billable entity for PBS?

MS. DOTY: Objection. Vague.

A. Again, I do not work for BBH. So I do not know when they started the pilot program. I can tell you it was in 2023 when Medicaid made the decision to in 2024 develop codes and rates for that.

Q. Okay. Prior to 2023, are you aware of anything that DoHS has done to increase the availability of services to positive behavioral support services?

MS. DOTY: Objection. Outside of the scope.

A. I do not know when BBH started the

pilot program.

Q. Other than that program --

A. Yes.

Q. -- are you aware of anything else that DoHS has done to increase accessibility to these services?

MS. DOTY: Objection. Outside of the scope.

A. Before that, no, I do not know.

Q. And would positive behavioral support services be considered wraparound services --

MS. DOTY: Objection.

Q. -- or community-based services?

MS. DOTY: Objection. Vague.

A. It is a community-based service.

Q. Are you aware of the wait list that is associated with the licensed behavioral health providers that provide the positive behavioral support services?

MS. DOTY: Objection. Vague.

A. I would need you to clarify. There is not a wait list for LBHCs.

Q. You aware of any wait lists with

the positive behavioral support services?

A. We have not started them yet. It would start in the fall of '24.

Q. So prior to 2023, DoHS hasn't provided behavioral health services at all?

MS. DOTY: Objection. Outside of the scope.

A. BBH piloted the program. I do not work for BBH. So I cannot speak to if they had a wait list or not.

Q. Then that means -- I am confused, and you need to clarify for me.

All right. I am going to hand you what I am having marked as Deposition Exhibit Number 1.

(Exhibit 1 was marked.)

Q. Are you familiar with the SME -- 2024 SME report?

A. I have viewed it, yes.

Q. If you go ahead and flip to page 64 of the report --

A. Okay.

Q. -- you will see there is an overview section talking about behavioral

support services. Are these the same behavioral support services that we are talking about?

MS. DOTY: Objection. Outside of the scope.

A. In the bottom two paragraphs -- I would like to clarify that that's what you are asking about. Where do you want me to look?

Q. Oh, just the -- I mean, it says -- should be -- make sure we are on the same page -- 64.

A. Okay.

Q. Yeah, sorry. I hate double-sided --

A. That's okay.

Q. So do you see where they are talking about behavioral support services where it starts with the overview under 3.8.

A. Yes. But behavior support services is not the same thing as PBS. So PBS is a model of doing behavior support services.

Q. So it is the manner in which they do it? It's not just the behavioral support

services as a whole?

A. Right. So behavior management again would be a form of behavior support services, which we already cover at Medicaid. We are just saying we are going to cover -- we are pushing the evidence-based model forward.

Q. Got you. Then help clarify this for me. If you look down at the very bottom, the last full paragraph says, As previously addressed. Do you see that there?

A. So, again, that would be with BBH's pilot program. So it says at the bottom, slots for the BBH, PBS program.

Q. So that's strictly BBH, and it's not DoHS?

A. That is DoHS but not Medicaid.

Q. So tell me again, what's BBH?

A. Bureau for Behavioral Health.

Q. And that's not under Medicaid?

A. No. We are separate bureaus. So Bureau for Medical Services and Bureau for Behavioral Health under DoHS.

Q. I thought there was -- so there's no Medicaid at all under BBH?

A. No. Those are separate -- completely separate bureaus.

Q. All right. Thank you.

So the non -- so BBH has started the program. You all are -- when I say you all -- BMS is adopting the program, but have not yet done so?

A. That's correct.

Q. So BMS implementing this model -- are you going to be providing the same services -- it will be the same -- typically the same services that BPH -- BBH is providing, correct?

MS. DOTY: Objection. Vague.

A. Yes. We are taking their pilot program and putting it in sustainability for Medicaid payment.

Q. But it will be different providers, I would imagine?

A. No.

Q. Same providers?

A. Yes.

Q. But you'll be adding Medicaid recipients?

A. They could get it now through the pilot program. We are making it sustainable through Medicaid to ensure for, one, is payment, two, tracking and data, claims and information. So what it does is -- when you have a pilot program, they're typically -- it is a short-term grant-funded thing. So what we're doing is saying we are going to take this and make it sustainable through Medicaid for reimbursement for the providers.

Q. And I guess my concern here -- or my question is, is if they are reporting wait lists through the providers under the BBH program, with you all taking on the program -- or taking on the program for foster children, is anything being done to address the fact that there currently is wait lists in the program that you are creating or adopting?

MS. DOTY: Objection. Vague.

A. The expectation is, since Medicaid

was sustained, that more providers will come on board. Sometimes it is difficult when you grant fund something because it is short term. Many providers don't want to take that upon. With Medicaid becoming the payor -- as a permanent payor, we believe more providers will come on board with that, and we will probably not have a wait list or we will have a small wait list, which again would be tracked by the managed care organizations once it becomes a Medicaid-payable service.

Q. When do they expect that to go live?

A. Again, fall of '24 is the tentative date for that policy to be in effect.

Q. So until that pilot program actually goes live so to speak, there is no way of knowing whether or not it is going to have an effect on the wait list; is that correct?

MS. DOTY: Objection. Outside the scope.

A. The pilot program -- so it's

separate. So it is not a pilot program. It is Medicaid. It's Medicaid sustained.

Q. Right. But your premise is that once it becomes a Medicaid-billable service, you will get more providers and hopefully reduce the wait lists. Through your-all's program, are you going to be adding more Medicaid individuals now that you are receiving services?

A. If an individual has Medicaid and they meet medical necessity for that service, they can receive the service.

Q. I understand that. But there's already individuals under BBH?

A. Correct.

Q. So my question is, are you just taking individuals already receiving services under BBH, or are you going to be adding new individuals receiving services under BMS?

A. If they meet medical necessity for the service, they would get it. So it would be not just the pilot people but anybody on Medicaid who meets medical assessment.

Q. Right. So you are going to be increasing the number of people receiving those services?

A. That is a possibility, yes, that's correct.

Q. Do you know of the current providers, if any of those are going to be Medicaid eligible?

MS. DOTY: Objection. Vague.

A. Providers are enrolled -- I am just going to clarify. Do you mean members or providers?

Q. I mean the providers under BBH, the ones that are currently providing these services under BBH, are they going to qualify under the program that DoHS is implementing under BMS?

MS. DOTY: Objection. Vague.

A. My understanding from BBH is, they are already enrolled in Medicaid as providers.

Q. All of them?

A. My understanding from BBH, they are.

Q. Are there any other programs that have been initiated by -- I'm sorry. Strike that.

Are there any other programs -- BBH programs that BMS is going to be adopting or is looking at adopting to increase accessibility?

A. We already did Children's Mobile Crisis. So that was a pilot program through BBH, which we had a state plan amendment approved from CMS. So we already have that approved and have already certified teams for Mobile Crisis.

Q. Any others?

A. Not at this time, no.

Q. Throw another acronym at you and ask you to define this so I don't have to look it up.

A. I'll try.

Q. RMHTFs?

A. Residential mental health treatment facilities.

Q. Thank you.

What if anything has DoHS done

since 2022 to increase access to RMHTFs?

MS. DOTY: Objection. Outside of the scope.

A. I wouldn't say there was increase. I think we developed community-based services to try to stop children from going to facilities. There is nothing we have done to open up more access to facilities. We put more community-based services in place to ensure that children could stay in the community more than go into the facility.

Q. Okay. And we talked about the CSED Waiver Program as one of those programs, correct?

A. That's correct.

Q. And what other programs have been created, or what -- let's start with that. What other programs have been created to accomplish that goal?

A. Well, Children's Mobile Crisis is one of them. So if someone is having a crisis, a crisis team is sent out to the home. And a lot of times that stops

children from going into emergency departments, which then could lead to a facility-based level of care.

So that's probably the children's crisis team. They go out and assess the situation. They are also able to schedule appointments immediately, the next day. Sometimes get them on the phone with the psychiatrist of the LBHC or with the clinical supervisor to get something set up immediately so we can stop that individual from possibly going into a facility-based care.

Q. And is there any matrix or any manner in which to track how many children are being prevented from going into RMHTFs through the Child's Mobile Crisis Program?

A. There is not a matrix developed.

Q. Has there been -- well, strike that.

Other than the Children's Mobile Crisis, any other programs or services that have been developed to help children from being -- or from going into the RMHTFs?

MS. DOTY: Objection. Outside of the scope.

A. We are in the process right now of developing CCBHCs in West Virginia - Comprehensive Community Behavioral Health Clinics.

Q. Hold on just a second. CCHB --

A. CCBHC.

Q. I can't tell -- too many C's in that. CCBHC?

A. CCBHC. And those are comprehensive community behavioral health clinics. And that is a federally recognized provider type. And our state -- in development of CCBHCs, states are allowed to require certain services. So we are requiring all CCBHCs -- they must be a CSED provider. They must have a Children's Mobile Crisis team. And they must have intensive outpatient programs for youth and adolescents.

Q. Give me an example of a CCBHC.

A. So, again, we are submitting a state plan amendment this month for

approval. But an example would be like -- Prestera is a comprehensive mental health center that is planning to apply to become a CCBHC. These comprehensive and LBHCs can render any services in Chapter 503 of our Medicaid manual.

But with this designation, because of the way the payment structure is, we can require them to do certain services, not just you have an option to do them. We are saying you have to serve certain populations and you must do these certain services. So with that, that will expand CSED Waiver providers, Children's Mobile Crisis teams and intensive outpatient programs for youth.

Q. And of those programs you just mentioned, how many of them are Prestera currently providing?

A. I'm sorry. Of the programs right now?

Q. Yes.

A. They have a CSED Waiver -- they are a CSED Waiver provider. And I believe they are applying with the Mobile Crisis Team. I

am not sure if they have one in place just yet.

Q. How long has the Mobile Crisis Program been in effect?

A. Since we -- we had a state plan amendment approved in September of '23. And our policy was effective February of '24.

Q. And as far as the CSED Waiver Program -- of the providers that you anticipate identifying as CCBHCs, do most of them already provide CSED Waiver?

A. I would say no based on it. But again, we don't know who all will apply. So it is not in effect yet. So we are not sure who all will apply.

Q. I'm sorry. When is that going to go into effect?

A. We are submitting the state plan amendment this month. So we do not know when CMS will have an effective date on that. But we do believe it will be by the end of '24 at latest.

Q. Other than -- hold on. I want to make sure I got your complete answer because

we went off on a tangent. Children's Mobile Crisis, CCBHC -- what other, if any, efforts is DoHS taking to reduce the number of children going into RMHTFs?

MS. DOTY: Objection. Outside of the scope.

A. I believe I have named the majority.

Q. I just want to make sure.

A. Yeah. I believe I named the majority of those services that have been placed by Medicaid.

Q. And of the services that -- and I understand several of these have not taken place yet, or at least a few of them are planning on going into effect. Have you realized any reduction in the actual amount of children going into the RMHTFs?

A. Aetna has reported to me that there has been a decrease in that. We don't know if it is connected to CSED or the other community-based services that have been put in place. It could be for multiple reasons that that number went in.

Q. Are you aware of the increase in the wait lists to RMHTFs?

MS. DOTY: Objection. Vague.

A. No, I cannot.

Q. When you take over the program -- take over is a bad -- when you implement plans that are currently being implemented by BBH, such as the -- did you ask where CCBHCs came from?

A. No.

Q. No, that was separate?

A. Yeah.

Q. Okay. Strike that. Let me ask you this way.

Prestera provides IDD Waiver services, right?

A. I don't -- I am not over IDD, so I don't have access to those providers.

Q. You say it does provide CSED Waiver Services?

A. Correct.

Q. So if there is a wait list for IDD Waiver and CSED Waiver, both of which provided Prestera and you are adding more

responsibilities to them, what confidence do you have that they will be able to actually handle the services it can be asked to provide?

MS. DOTY: Objection. Outside the scope.

A. The IDD Waiver and CSED are different populations. So they are not connected in any way.

Q. Right. But, I mean, Prestera is only -- I mean, I don't want to assume anything. Everybody knows who Prestera is. They only have so many employees. So if you are adding more programs, more services -- I understand that you have got multiple wait lists.

I guess my question is, has DoHS done anything to make certain or to assure that when Prestera is being asked to provide these additional services that they can actually do it?

A. So there was a demonstration grant that was won by West Virginia for CCBHCs, and that gave dollars to providers,

including Prestera, to develop more workforce to become a CCBHC provider.

Q. Are you aware that part of the reason Prestera, like other behavioral health centers, identify as the reason -- strike that. It's a horrible question.

With regard to CSED -- CSED Waiver Program specifically, do you know why there's wait lists?

MS. DOTY: Objection. Vague.

A. There could be multiple reasons for a wait list. There could be an influx of one time of one area getting more children. Also, you know, once school is in session, you are going to get more referrals versus in summer and November and December when you probably will have less referrals. So there is a fluctuation usually of the wait list depending on that.

Q. Separate from fluctuations -- and I understand there is obviously always environmental aspects that can make things go up and down. I mean, there has been a constant increase in percentage of wait

lists from 31 percent of organizations to 57. Do you know if DoHS has looked in to determine why that is?

MS. DOTY: Objection. Outside the scope.

A. I believe that has been reviewed. And partially is, it does take a while to train new employees with wrap-around and evidence-based practices. So it is not like you can hire someone and they can immediately go to work too.

So you are talking about at least a two to four-week session of them being trained before at times or even with families and with children to do that. And then, you know, there are times employees, that is not -- they realize through the training that that's not the population they want to serve, and they go a different route. Again, there's multiple reasons why there could be an increase in the number.

Q. Do you have an understanding of how long there has been a wait list with regard to CSED Waiver?

A. No. Because again, the pandemic put kind of a kink in our data. So it is really hard to judge based on 2021 and '22.

Q. What about prior to the pandemic?

A. It wasn't in effect. We went in effect during the pandemic in '20.

Q. And out of the 30 individuals that are currently on the CSED wait list, do you know how many organizations that it represents?

A. I do not.

Q. Other than Prestera, what other behavioral health facilities are you aware of that plan to apply for the CCBHC license?

A. We have six provisional right now that have informed us that they will. But once we have a state plan amendment, there could be more. Currently, it would be Prestera, Seneca, Southern Highlands, Valley -- I am thinking of everybody. Prestera, Seneca, Southern Highlands, Valley, FMRS -- and I am missing one. I'm sorry. I am missing one off the top of my head. I apologize.

Q. I am surprised you got five.

A. I have to think about it here. So Prestera, Seneca, Southern Highlands, FMRS, Valley. I am trying to think. We have six. I can't think of the sixth one right off the top of my head.

Q. When DoHS -- and my apologies. I know I asked this. I can't remember exactly what the answer was. What other programs that BBH operates that DoHS has kind of modeled or decided to take on? You have the Children's Mobile Crisis Program. What else?

MS. DOTY: Objection. Vague.

A. PBS.

Q. PBS?

A. And then also CCBHC started, which SAMHSA -- which is the federal entity that funds money to BBH.

Q. Okay. So all three of those were under BBH -- or where DoHS became aware of them because they are being operated by BBH?

MS. DOTY: Objection. Vague.

A. Yes.

Q. Did DoHS take a look at the success that BBH was having in terms of accessibility, wait lists, things of that nature in deciding to take on these programs?

MS. DOTY: Objection. Vague.

A. So when they pilot a program, they will do it anywhere from maybe two years to five years. And then we meet with Medicaid. And then we look at it. CCBHC is actually a state law that was passed here that we had to do a state plan amendment. That was required by the state law on how the payment structure of that was. But again, the money and the demonstration did come through BBH.

So we did look at PBS and Mobile Crisis. We saw the success. We also had hospital feedback that said this was helping them with EMEDs, with children coming there. So we knew that was something that we wanted to do. And so at that point we decided how we would do that.

One was state plan amendment. We did not have to do a state plan amendment

for PBS because we already had behavioral management under mental health rehab state plan.

Q. I'm sorry. Say that last part again.

A. I'm sorry.

Q. That's all right. That last part you just said, I didn't quite catch that.

A. Sorry. So we did not have to do a state plan for PBS because it is a model -- because we already have mental health rehabilitation state plan which included the behavioral management. We are just stating they are going to use a model to do behavior management services.

Q. So you weren't adding a new service, you were just changing the language you were providing it?

A. It actually is an additional service. So you have behavior management, and then you have people who are certified to do PBS. So we are not taking away behavioral management, we are saying you are using the evidence-based model and certified

individuals to do it.

Q. So with regard to the programs that you've identified -- well, it's not in effect yet, so I can't ask that question.

How do you monitor the success rate of the CSED Waiver Program?

MS. DOTY: Objection. Vague.

A. We have metrics in place. Our managed care organization is put together --

Q. Right. But, I mean, what are you looking at to say this is working?

MS. DOTY: Objection. Vague.

A. Again, I don't have those right in front of me right now, the metrics.

Q. Okay.

MS. DOTY: Can we take a break?

MR. WALTERS: Absolutely.

(Break in proceedings from 9:45 to 9:58 a.m.)

BY MR. WALTERS:

Q. I think you told me -- but let me ask you because I am not positive -- that there was a means by which the managed care group -- or the managed care company is

tracking the success of keeping children out of residential treatment facilities?

MS. DOTY: Objection. Vague.

A. They are supposed to be doing that, yes.

Q. And those numbers -- I mean, is that -- what I am trying to -- what I am trying to get at in a horrible way is, how is BMS and DoHS tracking or determining whether or not these programs - you know, absent the ones that haven't started - are keeping kids from going into residential treatment centers?

MS. DOTY: Objection. Outside of the scope.

A. They have -- especially Children's Mobile Crisis because it's just become a Medicaid service. They are working on the development of metrics so -- in reporting.

So, for an example, it could be the child went to the emergency department and the parents were like we think they need to go in-patient somewhere, but the Children's Mobile Crisis was able to, you know, put

them in connection with appointments and ensure that they had community-based services so they did not go in the program.

So this was an example of something that they would have to track. So I believe in Children's Mobile Crisis, there is a development right now of a reporting form on that.

Q. Do you know whether or not that tracking would include they didn't go within the next 30 days, 60 days, 90 days, as meaning we have stopped it from happening?

A. I do not know. Again, I believe that particular part is in development because it is a newer service.

Q. What about the -- is that type of tracking done for the CSED Waiver Program?

MS. DOTY: Objection. Vague.

A. My understanding is that there is. I do not have that report in front of me. So I do not know the algorithm or metrics that were developed with that.

Q. And, I mean, is it fair to say that the purpose or the goal of these community-

based services are to prevent in-patient care or residential treatment placement?

MS. DOTY: Objection. Outside of the scope.

A. That is correct.

Q. Okay. So in assessing whether or not these community-based services are actually working, those would be the numbers -- numbers of in-patient and number of individuals or children in foster care being placed in residential treatment -- residential treatment facilities would be an important matrix for DoHS?

MS. DOTY: Objection. Outside of the scope.

A. It could be one of them. But there could be multiple factors to that.

Q. And let's go back to that IDD Waiver a second. I think you told me that you are not over -- you're not over IDD Waiver?

A. No.

Q. Don't have anything to do with IDD Waiver?

A. No.
Q. But IDD Waiver, I thought -- isn't there Medicare IDD Waiver?
MS. DOTY: Objection. Vague.
A. Medicaid. You said Medicare.
Q. Sorry. Medicaid. I meant Medicaid.
A. Yeah. So there are different types of 1915(c)'s. So CSED Waiver is one of them. And because it is behavioral health related, and I'm the behavioral health director, it is in my unit. While there is another unit that does the IDD, the ADW and the TDI.
Q. And so ADW -- of course we are not dealing with ADW and the IDD. So if you are dealing with IDD in the realm of BMS, that's going to be through CSED?
MS. DOTY: Objection. Vague.
A. No. Those are separate waivers.
Q. Okay.
A. Separate target populations are served.
Q. And what I am trying to get a

handle on, that I obviously don't understand is -- I thought there was foster care children that received IDD Waiver services through Medicaid?

A. There are. But again, that would be children in foster care with a cognitive impairment who meet the qualifications for IDW. You might have children in foster care that have mental health conditions. That is CSED Waiver.

Q. Okay.

A. So it is a different --

Q. So the children in foster -- sorry. I didn't mean to cut you off.

A. That's okay.

Q. The children in foster care that have the IDW through Medicaid, that would not be in your purview?

A. That is correct.

Q. That would be BBH?

A. No.

Q. Who would that be?

A. Okay. So we are Medicaid --

Q. Right.

A. -- under DoHS.
Q. Right.
A. And then you have 1915(c)waivers. Those are defined as home and community-based waivers.
Q. Uh-huh.
A. You have the IDW Waiver, ADW Waiver, the TBI Waiver, and the CSED Waiver. Okay? Those are all separate 1915(c)'s.
Q. Got you.
A. Okay. What target populations that they serve.
So that is Medicaid. We are the payor of that. So a child that is on the IDD Waiver could be a foster child, could not be a foster child.
Q. Right.
A. But they have a severe cognitive impairment or a developmental delay, so they are served in that waiver for children who are --
Q. Okay. And that's what I want to talk about. So when you are talking about those children in that waiver, who is that

under? I know it's under --

A. Randy Hill's. That's a separate director.

Q. Okay.

A. It is a separate unit.

Q. In BMS?

A. In Medicaid, yes.

Q. So it is in BMS. It's in Medicaid. It is the IDW Waiver. And you can't talk about it because it is not over -- that's not something that you are prepared to talk about?

A. That is not my area.

Q. I understand.

Has BMS or DoHS looked into causes of community-based program services -- delays in children getting community-based services?

MS. DOTY: Objection. Outside of the scope.

A. Yes. We have reviewed, you know, certain individual cases. Aetna has brought cases to us to inform us there is a delay for certain reasons. It could be even that

the parent refuses services. So there is a freedom of choice. The family has a right to refuse a service even if the child meets medical necessity criteria.

So there's multiple reasons why services have not taken place. And so we look at those. If there is something that could be a barrier that we feel like we can work with the family or work with other entities, if that's the situation, then we do that.

So we do have what we call like case sessions where we have a particular issue, we are bringing it to DoHS or Medicaid in particular. They kind of staff it. And then we talk about what we can do to eliminate those barriers.

We have even had times where we think that the parents just need more education about the program. We are not, you know, coming in to like take your child. We are actually coming in to put services in your home to ensure your child can stay with you.

Q. And when you do that review, do you have any type of -- is there a report out there that says we have identified these reasons or -- you know, yeah. Is there a report of anything that identifies the reasons that you have identified causing these delays in community-based services?

MS. DOTY: Objection. Vague.

A. I don't believe there is a detailed report. I think there is an overall report of like if there are children on the wait list or on hold or things like that.

Q. And you mentioned wait list. I mean, fair to say that when you do that review, part of the reason -- or at least one of the causes is wait lists, receiving community-based services; is that fair?

MS. DOTY: Objection. Vague.

A. We do review that, yes.

Q. And there are wait lists, and that is part of the cause; is that fair?

MS. DOTY: Objection. Vague.

A. There is 30, as I stated earlier.

Q. Sorry. Can you repeat that?

A. There is 30 as of June 14th, as I stated earlier.

Q. That's just with the CSED?

A. Right.

Q. I am talking about in general, community-based programs -- services?

A. No. Because that's very different. That's program specific.

Q. One of the programs that you mentioned early on was the ACT Program, correct?

A. That's correct.

Q. I think I asked you if you know how many were in it. And you do not know, correct?

A. No. We have approved teams. And those teams can have up to 125 individuals on those teams.

Q. Are you aware that in -- what year are we in, 2024 -- middle of last year, that there was only five foster care or youths under the age of 21 receiving ACT Services?

A. I don't have the number in front of me.

Q. Would that surprise you?

MS. DOTY: Objection. Outside of the scope.

A. That there were that many individuals getting services for ACT?

Q. That few.

A. Well, you have to understand it is only 18 to 21. So, no, I am not --

Q. I'm sorry. Between 18 and 21?

A. Right. But the service is for 18 and up.

Q. Right.

A. So compared to, you know, 22 to 64, you are going to have a less population for 18 to 21.

Q. Right. So I guess what I'm -- when I asked you about programs that DoHS has implemented to help provide community-based services to foster children, ACT was mentioned. But as you said, ACT is only 18 to 21?

A. That's correct.

Q. So it is only going to target a very limited portion of the foster care

community?

A. Right. But you have CSED Waiver which is --

Q. Right.

A. -- which is -- if you look at it, it is almost ACT-like in a sense because you have wraparound.

Q. You said ACT-like, not ACT light?

A. Like, L-I-K-E.

Q. That's important.

A. Yeah.

So when you look at it that way -- so you almost have a program for adults and children. So the 18 to 21 is always an interesting population because they can sometimes receive children's services still because they are under 21 or adult services because they are 18 and up.

Q. When DoHS looked -- and we talked about looking at BBH for programs, and you mentioned the CCBHC and CSED and BPS -- PBS?

A. PBS.

Q. I don't know why it is so hard.

Were those programs chosen

specifically to reduce the amount of individuals -- amount of foster care children going into residential treatment?

MS. DOTY: Objection. Outside of the scope.

A. I think they were developed for all children, not just ones in the foster care system. So it was all children we were focused on to ensure that they didn't have to go into facility-based care.

Q. Right. But the purpose is to prevent the introduction of children into residential treatment?

MS. DOTY: Objection. Outside of the scope.

A. Your goal is to develop more community-based services to do that, that is correct.

Q. And I think -- is there any program out there that DoHS has -- through the Medicaid program, are there any other programs out there that -- whose goal is to prevent children from going into residential treatment facilities that we haven't talked

about?

MS. DOTY: Objection. Outside of the scope.

A. I believe it mentioned intensive outpatient services. So we are going to require CCBHCs to do that for the youth. We already do have some intensive outpatient programs for children.

And so what that does is, instead of just like if you went to therapy once a week, it is actually a three-day or five-day program that children go to. We work with the Department of Education to ensure the kids still get their education. But they are there between four to six hours a day to receive group therapies, individual therapies, supportive counseling and targeted case management.

So that is also -- like they come to the program, but they go home in the evenings. So we are still like on the continuum. You might have basic outpatient, intensive outpatient. And then further down the line, you might have residential care.

So, again, that's another type of service in the community to try to ensure that they can stay in the community.

Q. That's a new program?

A. No. Intensive outpatient program has been around for 25 years maybe.

Q. Okay. I misunderstood you. I thought you said it was new. I am like, that doesn't sound --

A. No. That is not new. But yeah, it is in place. But with the requirement of CCBHCs having to have them. Where they could have done it before, now they will be required to do that.

Q. So the change that we are talking about is a requirement that anybody -- any facility that wants to be a CCBHC has to provide those services. Do you know whether or not at least the five that you can recall that are applying currently provide that service?

A. I would say the majority do not right now.

Q. And you expect that to be in effect

by the end of 2024?

A. Our state plan amendment is being submitted to CMS this month. So depending on CMS's approval date, yes, we are looking at it by the end of 2024.

Q. And you brought a lot of documents with you today.

MR. WALTERS: And this is really a question for counsel. Are there any documents in there that are not Bates stamped?

MS. DOTY: There are three documents that are not Bates stamped. But we can produce those to you.

MR. WALTERS: What I would like is -- because I don't -- obviously I don't want more documents that I don't need -- yeah, a copy of the documents that are not Bates stamped, the index.

Q. And the outline you are working off of today, did you create that outline?

A. No, I did not.

MR. WALTERS: I want a copy of the outline.

MS. DOTY: Okay.

MR. WALTERS: Give us just a second. We are about done. But I need just a short break.

(Break in proceedings from 10:12 to 10:14 a.m.)

BY MR. WALTERS:

Q. We have been talking about programs that were provided by BBH that BMS is now getting Medicare coverage -- Medicaid coverage for. Are there any programs that BBH is operating whose purpose -- or at least part of the purpose is to prevent children from going into residential treatment that BMS is not trying to expand Medicaid coverage for?

MS. DOTY: Objection. Outside the scope.

A. Not at this time.

Q. You said you have been director of BMS for four years?

A. Yes.

Q. When was the decision first made to start -- to take -- to start considering the

idea of expanding Medicaid coverage to these particular BBH programs?

A. Well, I have been 16 years total in the department. Just four years as the director.

Q. So even better?

A. So yeah. So really probably the start of the conversations happened -- I know in 2016 is when we first started talking about like developing CSED for example. And then 2018, I want to say was really when BBH started out with like PBS -- started talking about PBS and Children's Mobile Crisis.

So really that 2016, 2018 was like the pre, pre-planning, I would call it. And then of course during the pandemic, we were trying to put services, you know, in place for these things, making sure we have CMS approval for payment and all of those things. So 2016, 2018 was really pre-planning.

Q. Okay. And is that when BBH started the programs or when Medicaid started -- or

when BMS started looking at the programs that BBH was already running?

A. So I couldn't give you the exact dates of when they started. They had conversations with us saying we are thinking about developing Children's Mobile Crisis and working with Concord University for PBS. So they always give us preliminary conversations of this is what we are thinking of doing. And as they go along, we meet with them to see how is it going. Because, you know, you want to make sure that it can be sustainable by Medicaid. We don't want to start programs that we have to stop.

Q. Right.

A. So that's why we have those conversations.

Q. So I think I -- and let me ask you this way because I think I understand now. So it is not like BBH was running any of these programs for 20 years and BMS came along and said, Oh, that's a great program, let us use it? It was when they started it,

you monitored it to see if it was sustainable and then decided to expand it to Medicaid?

A. We would meet with them usually -- sometimes once a month at least for an update, how is it going, what are you learning, what's working, what's not working. And then we also of course educate them on we think CMS would approve it if we do try these things and do these things. And so -- or you can show us data or documentation of your pilot program and how it is working. So that helps us build the state plan amendment, as well as the policy.

Q. And again, there is no -- so there is no certain -- there's no programs that BBH is current in operating. Are there any that are in the process of evaluating or beginning or considering --

MS. DOTY: Objection. Outside the scope.

Q. -- that would potentially apply to children -- trying to keep them out of residential treatment services?

MS. DOTY: Objection. Outside of the scope.

A. Not at this moment.

MR. WALTERS: Nothing further.

MS. DOTY: Okay. I would like to do a short cross, if that's fine?

MR. WALTERS: Sure. Absolutely.

EXAMINATION

BY MS. DOTY:

Q. Ms. Parsons, what is Aetna's role for providing Medicaid-covered services to foster children in West Virginia?

A. We have two different contracts of managed care organizations. One is Mountain Health Trust, and that is with all of our managed care organizations, including Unicare, the health plan, and Aetna. We will have another one called Highmark this coming year. Mountain Health Promise is the contract with Aetna that is particular to foster care and the CSED Waiver.

Q. When did the Mountain Health Promise contract go into place?

A. In 2020.

Q. Could you please describe what the reimbursement looks like for CCBHCs when that program gets off the ground?

A. Of course. So CCBHCs -- again, they are an identified provider type. And that is built upon what's called a PPS rate. So there are four options of PPS per state, PPS1, 2, 3 and 4. However, the state law that was passed for CCBHC required us to do what's called a daily encounter, which would be the PPS1 rate.

So the way I would explain it is, CCBHCs would be FQHC like, and that they're paid on a encounter rate basis. So if someone comes into a CCBHC and they get a service, they are paid an encounter no matter what type of service that they do as long as it is based within the encounter rate method of methodology.

So let's say someone came in and got therapy. They are paid the encounter rate, not the fee for service rate that you would typically get like at an LBHC.

Q. And what does PPS stand for?

A. Prospective payment system.
Q. What does FQHC stand for?
A. Federally Qualified Health Center.
Q. When you say an encounter rate, does that mean whatever service is provided, it all gets billed at like the per diem rate if it is a per diem payment?
A. Yes. So there would be codes built under that bundle of that encounter. So whatever those codes are. There may be some codes outside of it, some of them. But the majority would be under that encounter rate.
Q. So does whatever code for the particular service, like outpatient therapy --
A. Uh-huh.
Q. -- it gets rolled up into the like umbrella encounter rate? Is that how it works?
A. That's correct.
Q. Has BMS done anything to increase reimbursement rates for service providers since 2020?
A. So -- yes. So during the actual

pandemic, we gave a 70 percent increase, which was a temporary one during the emergency pandemic order. And 85 percent of the 70 percent rate was for direct care service workers. So the providers had to sign an attestation stating that we will take 85 percent of that 70 percent increase and ensure it goes to our workers. Because we wanted to ensure it retained workforce during COVID. Because a lot of them worked in -- face-to-face with a lot of individuals. And so we didn't want to lose our current workforce during the pandemic.

After the pandemic order was over, we did a permanent 5 percent rate increase for all behavioral codes for LBHCs.

Q. Okay. Does DoHS have any plans related to affordability of health records for children in foster care?

A. Yes. That is actually -- so right now we are working with Aetna, who again has that contract. And what they are going to develop is called -- it's kind of called an electronic health record passport, or an

electronic -- a mobile electronic health record.

So what that means is, is they are going to develop that to have -- everyone to have access to the same information that it needs to have, whether -- it could be the worker, the guardian, the providers, managed care organization. And the reason to do that is to ensure that everyone is on the same page about the person's care and they have access to all of the same information at the right time.

Q. Has DoHS made any amendments or changes to the CSED Waiver since 2020?

A. I think there was one update. But we are currently in draft right now since the 1915(c) Waiver is in with CMS for approval for changes.

So let me look right here. Number nine. I believe it was updated in '21.

Q. Okay. And do you know off the top of your head what those changes were in 2021?

A. It was mostly just clarification of

policy information. So once you have a policy out -- as providers ask questions, we develop what's called FAQs - frequently asked questions. And we take those FAQs and put them in the next policy amendment to make sure it is clarified for all providers.

Q. And then has DoHS made any changes to the reimbursement methodology for CSED Waiver providers recently?

A. We are working with CMS to have an update to the payment methodology. We have to have permission for that approval. That approval, I think we just got Friday actually. So it will be what's called a PMPM, which that lessens the administrative burden for CSED Waiver providers. And we have had several providers tell us that where they weren't doing CSED before, they probably would now because that's an ease of billing administration and time.

So we are going to put that into effect. So that's why the policy is in draft. We had to wait for CMS to approve the 1915(c) Waiver application. And now

that they have, we will then change that payment methodology in our systems.

Q. And what does PMPM stand for?

A. Per member per month.

Q. Can you explain how that works? What does a provider do and how do they get paid?

A. Sure. So there's a couple of ways Medicaid can do it. We have PMPWs or PMPMs. So PMPM is like we pay a set rate to the provider for that person, and they do all of the services for that calendar month. And the reason the payment becomes together is because actuaries look at other states and they look at our current claim system and they develop that rate.

So it is not exactly like an encounter rate, but it is a set rate per member per month. And the reason that is, is because you may have some children that need a lot of services in a month and some that may need not as many services. So they take that average. And it allows to free up time for the providers, not to do so much

documentation or administration overload to do the billing of individual codes.

MS. DOTY: Okay. I don't have any further questions. Thank you.

MR. WALTERS: Unfortunately, I do. But not many.

THE WITNESS: Okay.

RE-EXAMINATION

BY MR. WALTERS:

Q. You had mentioned the 85 percent raise that direct care workers received during the pandemic, correct?

A. Uh-huh.

Q. Yes? Sorry.

A. Yes. I'm sorry.

Q. You are all right.

A. I got a drink there.

Q. Whose idea was that?

A. Commissioner Bean really -- and worked with -- and I think it was -- our secretary and our deputy secretaries worked together. I think all states at that time - I will be honest -- were in panic mode. So we were all talking together as well to

figure out what we needed to do. We knew our biggest concern was workforce retainment. And so that's why our leadership came together and made that decision. And we had CMS approval.

Q. And I think you indicated that the providers were required to provide 85 percent of the moneys directly to the direct care workers, correct?

A. That's correct. They had to sign an attestation.

Q. And then it reduced to 5 percent when the program ended?

MS. DOTY: Objection. Vague.

A. Once the ARPA dollars, is what it was called, for the federal government ended, we still felt like we needed to do an increase for our providers. So we found 5 percent based on our budget.

Q. Was there any effort to track the amount of direct care workers who quit when their pay was reduced by 80 percent?

MS. DOTY: Objection. Outside of the scope, and mischaracterizes --

Q. When their bonus or their additional funding of 80 percent was reduced to 5?

MS. DOTY: Objection. Mischaracterizes testimony.

A. I do not know on that fiscal policy.

Q. But you understand what I'm asking. 85 percent was given to direct care workers, correct?

A. Uh-huh.

MS. DOTY: Objection. Mischaracterizes testimony.

Q. Right?

A. 85 percent of the 70 percent increase was required to go to direct care service workers.

Q. And then when the ARPA program ended, that 85 became a 5 percent permanent raise?

MS. DOTY: Objection. Mischaracterizes testimony.

A. It did become a 5 percent permanent raise.

Q. And I think you said you don't know. But was there any effort to determine how many direct care workers left when that 85 percent was reduced to 5 percent?

MS. DOTY: Objection. Mischaracterizes testimony.

A. I do not know.

MR. WALTERS: I have nothing further.

MS. DOTY: We would like the opportunity to have Ms. Parsons read and sign the transcript before it is finalized.

(Deposition concluded at 10:27 a.m.)

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CERTIFICATE

I, Tara Arthur, Certified Stenotype Reporter and Notary Public, do hereby certify that the foregoing deposition of the above-named witness, was duly taken by me in machine shorthand, and that the same were accurately written out in full and reduced to computer transcription.

I further certify that I am neither attorney or counsel for, nor related to or employed by any of the parties to the action in which this deposition is taken; and furthermore, that I am not a relative or employee of any attorney or counsel employed by the parties hereto or financially interested in the action.

My commission expires April 16, 2027.

Tara Arthur
Certified Court Reporter/Notary Public